UNIVERSITY OF MAINE SYSTEM
Aetna Medicare[SM] Plan (PPO)
Medicare (C02) PPO
Custom Rx: $9-$10/$25/$40/$55

Benefits and Premiums are effective January 1, 2027 through December 31, 2027

PLAN DESIGN
PROVIDED BY AETNA LIFE INSURANCE COMPANY

**Primary Care Physician (PCP):** You have the option to choose a PCP. When we know who your provider is, we can better support your care.

**Referrals:** Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

**Prior Authorizations:** Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

| PLAN FEATURES | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Annual Deductible** | $300 | $300 |

This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.

**Services Exempt from Deductible:**

Annual wellness exams, routine physical exam, routine mammograms, diagnostic mammogram, routine hearing exam, routine colorectal screening, routine prostate screening, bone mass measurement, immunization, routine GYN, routine eye care, kidney disease education, Medicare diabetic prevention program (MDPP), Medicare-covered $0 preventive services, additional Medicare preventive care services, Medicare Part B Rx, Part B Drugs - Insulin, Continuous Glucose Monitors (CGMs), diabetic supplies, emergency room, emergency ambulance services, some Medicare-covered diagnostic tests and labs (Urine protein, Prothrombin testing, HBA1C, FIT Screening, Fundus Testing, gFOBT Testing and COVID lab tests), Wigs, Teladoc, urgently needed care and renal dialysis.

**Out-of-network services exempt from Deductible:**

Annual wellness exams, routine physical exam, routine mammograms, routine hearing exam, routine colorectal screening, routine prostate screening, bone mass measurement, immunization, routine GYN, routine eye care, kidney disease education, Medicare diabetic prevention program (MDPP), Medicare-covered $0 preventive services, additional Medicare preventive care services, emergency room, emergency ambulance services, Part B Drugs - Insulin, Wigs, and urgently needed care.

| **Annual Maximum Out-of-Pocket Amount** | **Network Services:** | **Network and out-of-network services:** |
|---|---|---|
| Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. | $2,750 | $2,750 for in and out-of-network services combined |

It will apply to all medical expenses except Medicare prescription drug coverage that may be available on your plan.

| **HOSPITAL CARE*** | **This is what you pay for network providers.** | **This is what you pay for out-of-network providers.** |
|---|---|---|
| **Inpatient Hospital Care** | $200 per stay | 20% per stay |
| The member cost sharing applies to covered benefits incurred during a member's inpatient stay. | | |
| **Observation Stay** | Your cost share for Observation Care is based upon the services you receive | Your cost share for Observation Care is based upon the services you receive |
| Frequency: | per stay | per stay |
| **Outpatient Services & Surgery** | 10% | 20% |
| **Ambulatory Surgery Center** | 10% | 20% |
| **PHYSICIAN SERVICES** | **This is what you pay for network providers.** | **This is what you pay for out-of-network providers.** |
| **Primary Care Physician Visits** | $20 | 20% |
| Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery. | | |
| **Physician Specialist Visits** | $35 | 20% |

| PREVENTIVE CARE | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| Alcohol Misuse Screening & Counseling | $0 - 1 screening and up to 4 counseling sessions every 12 months for those who qualify | 20% |
| Annual Wellness Visit | $0 - 1 visit every 12 months | 20% |
| Bone Mass Measurement | $0 - 1 visit every 24 months or more frequently if medically necessary | 20% |
| Cardiovascular Disease Screening Test | $0 - 1 test every 5 years (60 months) | 20% |
| Cervical Cancer Screening with Human Papillomavirus (HPV) Test | $0 - 1 visit every 5 years (60 months) | 20% |
| Colorectal Cancer Screening | $0 - Once every 120 months (10 years) or 48 months after a previous sigmoidoscopy; $0 - Once every 24 months (unless patient got a screening flexible sigmoidoscopy; then we may cover a screening colonoscopy only after at least 47 months) | 20% |
| Counseling to Prevent Tobacco Use | $0 - 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year) | 20% |

| | | |
|---|---|---|
| COVID-19 Vaccine & Administration | $0 - Review the FDA emergency use authorization (EUA) criteria for each vaccine | $0 |
| Depression Screening | $0 - 1 screening every 12 months in a primary care setting | 20% |
| Diabetes Screening | $0 - 2 screenings within the 12-month period following the date of the patient's most recent diabetes screening test | 20% |
| Diabetes Self-Management Training (DSMT) | $0 - up to 10 hours within the first 12 months of the first year and 2 hours of follow-up training every following year | 20% |
| Flu Shot & Administration | $0 - 1 per year or more if medically necessary | $0 |
| Glaucoma Screening | $0 - 1 glaucoma screening each year | 20% |
| Hepatitis B Screening | $0 - 1 screening every 12 months, 2 screenings every 12 months if pregnant | 20% |
| Hepatitis B Shot & Administration | $0 - 2, 3, or 4 doses depending on vaccine or condition | $0 |
| Hepatitis C Screening | $0 - 1 screening every 12 months, if qualified | 20% |

| | | |
|---|---|---|
| HIV screening & HIV PrEP | $0 - 1 screening exam every 12 months; $0 - Up to 3 screening exams during a pregnancy. Up to 8 screening exams and/or counseling sessions when using FDA-approved lab tests and point-of-care tests. | 20% |
| Intensive Behavior Therapy (IBT) for Cardiovascular Disease (CVD) | $0 - 1 visit every 12 months with your PCP | 20% |
| Intensive Behavior Therapy (IBT) for Obesity | $0 - Up to 22 visits every 12 months for those who qualify | 20% |
| Initial Preventive Physical Exam (IPPE) | $0 - 1 time visit within the first 12 months you have Medicare Part B. | 20% |
| Lung Cancer Screening with Low Dose Computed Tomography (LDCT) | $0 - 1 screening every 12 months, if qualified | 20% |
| Mammography Screening | $0 - 1 screening exam every 12 months; $0 - each diagnostic mammogram when medically necessary | 20% |
| Medical Nutritional Therapy | $0 - up to 12 15-minute session or 3 hours within the first 12 months of the first year and up to 2 hours every following year for those with a qualifying diagnosis | 20% |
| Medicare Diabetes Prevention Program (MDPP) | $0 - 1 per lifetime per procedure for those who qualify | $0 |
| Pneumococcal Shot & Administration | $0 - 1 per year or more if medically necessary | $0 |

| | | |
|---|---|---|
| Prolonged Preventive Services | $0 - Frequency varies according to the specific Medicare preventive service. | 20% |
| Prostate Cancer Screening | $0 - 1 screening every 12 months | 20% |
| Screening Pap Test | $0 - 1 every 24 months or one every 12 months if at high risk | 20% |
| Screening Pelvic Exams | $0 - 1 every 24 months or one every 12 months if at high risk | 20% |
| Sexually Transmitted Infection Screening & High Intensity Behavioral Counseling(HIBC) to Prevent STI | $0 - 1 screening every 12 months or at certain times during pregnancy. | 20% |
| Ultrasound Abdominal Aortic Aneurysm (AAA) Screening | $0 - one screening per lifetime | 20% |
| **EMERGENCY AND URGENT MEDICAL CARE** | **This is what you pay for network providers.** | **This is what you pay for out-of-network providers.** |
| **Emergency Care; Worldwide** | $100 | $100 |
| **Urgently Needed Care; Worldwide** | $40 | $40 |
| **DIAGNOSTIC PROCEDURES*** | **This is what you pay for network providers.** | **This is what you pay for out-of-network providers.** |
| **Diagnostic Radiology** CT scans | $50 | 20% |
| **Diagnostic Radiology** Other than CT scans | $50 | 20% |
| **Lab Services** | $0 | 20% |
| **Diagnostic testing & procedures** | $20 | 20% |
| **Outpatient X-rays** | $20 | 20% |

| HEARING SERVICES | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Routine Hearing Screening**<br>We cover 1 exam every 12 months | $0 | 20% |
| **Medicare Covered Hearing Examination** | $35 | 20% |
| **DENTAL SERVICES** | **This is what you pay for network providers.** | **This is what you pay for out-of-network providers.** |
| **Medicare Covered Dental*** | $35 | 20% |
| Non-routine care covered by Medicare. | | |
| **VISION SERVICES** | **This is what you pay for network providers.** | **This is what you pay for out-of-network providers.** |
| **Routine Eye Exams**<br>One annual exam every 12 months. | $0 | 20% |
| **Diabetic Eye Exams** | $0 | 20% |
| **Medicare Covered Eye Exam** | $35 | 20% |
| **MENTAL HEALTH SERVICES*** | **This is what you pay for network providers.** | **This is what you pay for out-of-network providers.** |
| **Inpatient Mental Health Care** | 0% per stay | 20% per stay |
| The member cost sharing applies to covered benefits incurred during a member's inpatient stay. | | |
| **Outpatient Mental Health Care**<br>Individual visit | $0 | 20% |
| **Partial Hospitalization** | $0 | 20% |
| **Intensive Outpatient Services** | $0 | 20% |
| **Inpatient Substance Abuse** | 0% per stay | 20% per stay |
| The member cost sharing applies to covered benefits incurred during a member's inpatient stay. | | |
| **Outpatient Substance Abuse**<br>Individual visit | $0 | 20% |

| SKILLED NURSING SERVICES* | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Skilled Nursing Facility (SNF) Care** | $0 per day, days 1-20; $100 per day, days 21-100 | 20% per day, days 1-100 |

Limited to 100 days per Medicare Benefit Period.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

| OUTPATIENT REHABILITATION SERVICES* | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Outpatient Rehabilitation Services** (Speech, physical, and occupational therapy) | $20 | 20% |

| AMBULANCE SERVICES | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Ambulance Services** | 10% | 20% |

Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.

| TRANSPORTATION SERVICES | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Transportation (non-emergency)** | 24 one-way trips with 60 miles allowed per trip | |

| MEDICARE PART B PRESCRIPTION DRUGS* | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Medicare Part B Prescription Drugs** | $0 | 20% |
| **Medicare Part B Prescription Drugs - Insulin** | $0 | $0 |

| MEDICARE PART D PRESCRIPTION DRUGS | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.** | | |

| ADDITIONAL PROGRAMS AND SERVICES (MEDICARE-COVERED) | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Acupuncture**<br>Medicare covered benefits only. | $25 | 20% |
| **Allergy Shots** | $0 | $0 |
| **Allergy Testing** | $0 | $0 |
| **Blood**<br>All components of blood are covered beginning with the first pint. | $0 | 20% |
| **Cardiac Rehabilitation Services** | $20 | 20% |
| **Intensive Cardiac Rehabilitation Services** | $20 | 20% |
| **Chiropractic Services*** <br>Medicare covered benefits only. | $20 | 20% |
| **Continuous Glucose Monitors*** | $0 | $0 |
| **Continuous Glucose Supplies** | $0 | $0 |
| **Diabetic Supplies***<br>Includes supplies to monitor your blood glucose. | $0 | $0 |
| **Durable Medical Equipment/ Prosthetic Devices*** | 10% | 20% |
| **Home Health Agency Care*** | $0 | 20% |
| **Hospice Care** | Covered by Original Medicare at a Medicare certified hospice. | |

| | | |
|---|---|---|
| **Medical Supplies*** | Your cost share is based upon the provider of services | Your cost share is based upon the provider of services |
| **Outpatient Dialysis Treatments*** | $0 | $0 |
| **Podiatry Services** | $35 | 20% |
| Medicare covered benefits only. | | |
| **Pulmonary Rehabilitation Services** | $20 | 20% |
| **Radiation Therapy*** | $20 | 20% |
| **Supervised Exercise Therapy (SET) for PAD Services** | $20 | 20% |
| **Telehealth** | Covered | |
| Telemedicine Services. Member cost share will apply based on services rendered. | | |
| Telehealth PCP | $20 | 20% |
| Telehealth Specialist | $35 | 20% |
| Telehealth Occupational Therapy Services | $20 | 20% |
| Telehealth PT and SP Services | $20 | 20% |
| Telehealth Other Health care Providers | $35 | 20% |
| Telehealth Individual Mental Health | $0 | 20% |
| Telehealth Group Mental Health | $0 | 20% |
| Telehealth Individual Psychiatric Services | $0 | 20% |
| Telehealth Group Psychiatric Services | $0 | 20% |
| Telehealth Individual Substance Abuse Services | $0 | 20% |
| Telehealth Group Substance Abuse Services | $0 | 20% |
| Telehealth Kidney Disease Education Services | $0 | 20% |
| Telehealth Diabetes Self-Management Training | $0 | 20% |
| Telehealth Opioid Treatment Program Services | $0 | 20% |
| Telehealth Urgent care | $40 | $40 |

| ADDITIONAL PROGRAMS AND SERVICES (NOT COVERED BY ORIGINAL MEDICARE) | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Routine Physical Exams**<br>One exam per calendar year | $0 | 20% |
| **Smoking and Tobacco Use Cessation Supplies** | $0 | 20% |
| Frequency | unlimited visits every year | unlimited visits every year |
| **Teladoc™** | $0 | |
| Telemedicine services with a Teladoc™ provider. State mandates may apply. | | |
| **Wigs*** | $0 | $0 |
| Maximum | $400 | |
| Frequency | every year | |

| OPTIONAL PROGRAMS AND SERVICES (NOT COVERED BY ORIGINAL MEDICARE) | This is what you pay for network providers. | This is what you pay for out-of-network providers. |
|---|---|---|
| **Acupuncture - Non-Medicare Covered** | $25 | 20% |
| Coverage | in lieu of anesthesia and for treatment of chronic pain | in lieu of anesthesia and for treatment of chronic pain |
| Frequency | unlimited visits every year | unlimited visits every year |
| **Enhanced Chiropractic Services**<br>Visits: unlimited visits every year | $20 | 20% |
| **Cervical and Vaginal Cancer Screening (non-Medicare covered)** | $0 | 20% |
| In addition to the Medicare-covered services listed above, we cover 1 exam every 12 months | | |
| **Fitness Benefit** | SilverSneakers® | |
| **Healthy Rewards** | Covered | |
| **Meals** | $0 | |
| Discharge Type | Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility | |
| Number of meals | 14 | |
| Number of Days | 7 | |
| Vendor | NationsMarket | |
| **Resources For Living®** | Covered | |
| For help locating resources for every day needs. | | |
| **Urine Test Strips** | $0 | $0 |

**Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.**

See next page for Pharmacy-Prescription Drug Benefits.

UNIVERSITY OF MAINE SYSTEM
Aetna Medicare[SM] Plan (PPO)
Medicare (C02) PPO
Custom Rx: $9-$10/$25/$40/$55

## PHARMACY - PRESCRIPTION DRUG BENEFITS

**Pharmacy Network** P1

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com.)

**Formulary (Drug List)** Classic Plus

**Calendar-Year Deductible for Prescription Drugs** $0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible. The deductible does not apply to covered insulins and most Part D vaccines.

**Initial Coverage Phase** - The table below represents cost sharing after the deductible, if applicable, has been reached.

| 4 Tier Plan | 30-day Supply through Retail | | 90-day Supply through Retail or Mail | | |
|---|---|---|---|---|---|
| | **Preferred** | **Standard** | **Preferred Retail** | **Preferred Mail** | **Standard Retail or Mail** |
| **Tier 1 - Generic** Generic Drugs | $9 | $10 | $18 | $18 | $20 |
| **Tier 2 - Preferred Brand** Preferred Brand Drugs | $25 | $25 | $50 | $50 | $50 |
| **Tier 3 - Non-Preferred Brand** Non-Preferred Brand Drugs | $40 | $40 | $80 | $80 | $80 |
| **Tier 4 - Specialty** Includes high-cost/unique generic and brand drugs | $55 | $55 | Limited to one-month supply | Limited to one-month supply | Limited to one-month supply |

**If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a standard network retail pharmacy and you may receive up to a 31 day supply.**

**You won't pay more than $35 for a one-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.**

| | |
|---|---|
| **Catastrophic Coverage:** | You pay $0 for covered Part D prescription drugs. |

Catastrophic Coverage benefits start once the CMS-determined annual out-of-pocket threshold of $2,400 for covered Part D prescription drugs is reached.

| | |
|---|---|
| **Requirements:** | |
| **Precertification** | Applies |
| **Step-Therapy** | Applies |

**Non-Part D Supplemental Benefit**

- Agents used for cosmetic purposes or hair growth
- Agents used to promote fertility
- Agents when used for the symptomatic relief of cough and colds
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Agents when used for weight loss
- Miscellaneous agents
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

## Medical Disclaimers

**Not all PPO Plans are available in all areas**

The provider network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be

guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC).

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

## Pharmacy Disclaimers

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the

source of applicable payment (Medicare Part D, plan sponsor or member).

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Members who get “extra help” don’t need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered “mail-order pharmacies.” Therefore, most specialty drugs are not available at the mail-order cost share.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for “off label” use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

**Your plan includes supplemental coverage for some drugs not typically covered by a Medicare Part D plan.** Refer to the "Non-Part D Supplemental Benefit" section in the chart above. Non-Part D drugs covered under the enhanced drug benefit can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan.

## Plan Disclaimers

Aetna Medicare is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

You can read the *Medicare & You 2027* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You can also visit our website at http://www.aetnaretireeplans.com. As a reminder, our website has

the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to http://www.aetna.com.

***This document is not intended to be member-facing as it does not include the required disclosures.***

*****This is the end of this plan design*****

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**Approved By:**

**Date:**